Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Fuzeon Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for Fuzeon. Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility	Height	Weight	

Medical and medication information (Please provide copies of all pertinent medical records.)

Laboratory Results

Date	CD4 (cells/ml)	Plasma RNA (copies/ml)

If the CD4 count is > 500 cells/ml or plasma RNA is < 1000 copies/ml, please provide further justification for Fuzeon use.

Resistance testing
Please provide documentation of 2-class resistance, including copies of genotype/phenotype. If not available, please provide further justification for Fuzeon use (treatment history, etc.).

Intolerance to medications
Please list adverse reactions to antiretroviral medications.

Treatment plan
Please provide proposed treatment plan.

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Medical and medication information (cont.)

Fuzeon dose ☐ 90 mg SC BID
Other (specify) _____

Please explain rationale for doses other than Fuzeon 90 mg SC BID.

Continuation of therapy

If member is currently receiving Fuzeon therapy, please provide date started: _____

Please list baseline (CD4 (cells/ml) and plasma RNA (copies/ml) prior to start of Fuzeon.)

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I understand that if this patient does not show an adequate response to this medication within six months, reapproval will not be granted. I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date